

**CITY OF MONTGOMERY CLAIM CONTROL FORM**

**EMPLOYEE** \_\_\_\_\_ **DATE OF INJURY** \_\_\_\_\_

**DEPARTMENT** \_\_\_\_\_ **SSN** \_\_\_\_\_

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**EMPLOYEE NOTIFICATION**

I was injured while performing duties related to my employment with the City of Montgomery and understand that if I need to see a doctor, I must tell my supervisor so he can make arrangements for me to go to a CITY AUTHORIZED doctor. I understand that if I go to a doctor without CITY AUTHORIZATION, the expense from such visit will not be covered under Workers' Compensation.

**DO YOU REQUEST MEDICAL TREATMENT AT THIS TIME?**      YES      NO

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

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**THIS PORTION IS TO BE COMPLETED BY THE WORKERS' COMPENSATION OFFICE**

1. Referred to: \_\_\_\_\_ By: \_\_\_\_\_

Reason: \_\_\_\_\_ Date: \_\_\_\_\_

**APPROVED:** \_\_\_\_\_

2. Referred to: \_\_\_\_\_ By: \_\_\_\_\_

Reason: \_\_\_\_\_ Date: \_\_\_\_\_

**APPROVED:** \_\_\_\_\_

3. Referred to: \_\_\_\_\_ By: \_\_\_\_\_

Reason: \_\_\_\_\_ Date: \_\_\_\_\_

**APPROVED:** \_\_\_\_\_

4. Referred to: \_\_\_\_\_ By: \_\_\_\_\_

Reason: \_\_\_\_\_ Date: \_\_\_\_\_

**APPROVED:** \_\_\_\_\_